SUBCHAPTER G - PROSPECTIVE AND CONCURRENT REVIEW OF HEALTH CARE

§134.600. Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.

(a) The following words and terms, used in this section shall have the following meanings, unless the context clearly indicates otherwise:

(1) Ambulatory surgical services: surgical services provided in a facility that operates primarily to provide surgical services to patients who do not require overnight hospital care;

(2) Concurrent review: a review on on-going health care listed in subsection (i) of this section for an extension of treatment beyond previously approved health care listed in subsection (h) of this section;

(3) Final adjudication: the Commissioner has issued a final decision or order that is no longer subject to appeal by either party;

(4) Outpatient surgical services: surgical services provided in a freestanding surgical center or a hospital outpatient department to patients who do not require overnight hospital care;

(5) Preauthorization: prospective approval obtained from the insurance carrier (carrier) by the requestor or injured employee (employee) prior to providing the health care treatment or services (health care); and

(6) Requestor: the health care provider or designated representative, including office staff or a referral health care provider/health care facility who requests preauthorization, concurrent review or voluntary certification.

(b) The carrier is liable for all reasonable and necessary medical costs relating to the health care:

(1) listed in subsection (h) or (i) of this section, only when the following situations occur:

(A) an emergency, as defined in 133.1 of this title (relating to Definitions);

(B) preauthorization of any health care listed in subsection (h) of this section was approved prior to providing health care;

(C) concurrent review of any health care listed in subsection (i) of this section was approved prior to providing health care; or

(D) when ordered by the Commissioner; or

(2) per subsection (j) of this section, when voluntary certification was requested and payment agreed upon prior to providing the health care, for any health care not listed in subsection (h) of this section.

(c) The carrier is not liable under subparagraphs (b)(1)(B) or (C) of this section if there has been a final adjudication that the injury is not compensable or that the health care was provided for a condition unrelated to the compensable injury.

(d) The carrier or its agent, to include utilization review agent (carrier) shall designate accessible direct telephone and facsimile numbers, and may designate an electronic transmission address for use by the requestor or employee to request preauthorization or concurrent review during normal business hours. The direct number shall be answered or the facsimile or electronic transmission address responded to by the carrier within the time limits established in subsection (f) of this section.

(e) The requestor or employee shall request and obtain preauthorization from the carrier prior to providing or receiving health care listed in subsection (h) of this section. Concurrent review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (i) of this section. The request shall:

(1) be sent to the carrier by telephone, facsimile, or electronic transmission;

(2) include:

(A) the specific health care listed in subsections (h) or (i) of this section;

(B) the number of specific health care treatments and the specific period of time requested to complete the treatments;

(C) the medical information to substantiate the need for the health care recommended;

(D) the accessible telephone and facsimile numbers and may designate an electronic transmission address for use by the carrier;

(E) the name of the provider performing the health care; and

(F) the facility name and estimated date of proposed health care.

(f) The carrier shall:

(1) approve or deny requests for preauthorization or concurrent review based solely upon the reasonable and necessary medical health care required to treat the injury, except as provided by Texas Labor Code §408.0042(d), regardless of:

(A) unresolved issues of compensability, extent of or relatedness to the compensable injury;

(B) the carrier's liability for the injury; or

(C) the fact that the employee has reached maximum medical improvement;

(2) prior to the issuance of a denial, afford the requestor a reasonable opportunity to discuss the clinical basis for a denial with the appropriate doctor or health care provider performing the review;

(3) contact the requestor or employee by telephone, facsimile, or electronic transmission with the decision to approve or deny the request:

(A) within three working days of receipt of a request for preauthorization; or

(B) within three working days of receipt of a request for concurrent review, except for health care listed in subsection (i)(1) of this section, which is due within one working day of the receipt of the request;

(4) send written notification of the approval or denial of the request, within one working day of the decision to:

(A) the employee;

(B) the employee's representative; and

(C) the requestor, if not previously sent by facsimile or electronic transmission;

(5) include in an approval:

(A) the specific health care;

(B) number of requested health care treatments and the requested specific period of time to complete the treatments approved; and

(C) notice of any unresolved denial of compensability or liability or an unresolved dispute of extent of or relatedness to the compensable injury;

(6) include in a denial:

(A) the description or source of screening criteria used, the principal reasons, and clinical basis for making the denial; and

(B) plain language notifying the employee of the right to timely request reconsideration of the health care denied under subsection (g) of this section;

(7) not withdraw an approval once issued; and

(8) not condition an approval or change any elements of the request as listed in subsection (e)(2), unless the condition or change is mutually agreed to by the health care provider and carrier and the agreement is documented.

(g) If the response is a denial of preauthorization the requestor or employee may request reconsideration of the denied health care. If the response is a denial of health care requiring concurrent review, the requestor may request reconsideration of the denied health care.

(1) The requestor or employee may, within 15 working days of receipt of a written denial, request the carrier to reconsider the denial and shall document the reconsideration request.

(2) The carrier shall respond to the request for reconsideration of the denial:

(A) within five working days of receipt of a request for reconsideration of denied preauthorization; or

(B) within three working days of receipt of a request for reconsideration of denied concurrent review, except for health care listed in subsection (i)(1), which is due within one working day of the receipt of the request;

(3) The requestor or employee may appeal the denial of a reconsideration request by filing a dispute in accordance with Texas Labor Code §413.031 and §§133.305, 133.307 and 133.308 of this title (relating to Medical Dispute Resolution; Medical Dispute Resolution of a Fee Dispute; and Medical Dispute Resolution by Independent Review Organization).

(4) A request for preauthorization for the same health care shall only be resubmitted when the requestor provides objective documentation to support that a substantial change in the employee's medical condition has occurred. The carrier shall review the documentation and determine if a substantial change in the employee's medical condition has occurred.

(h) The non-emergency health care requiring preauthorization includes:

(1) inpatient hospital admissions including the principal scheduled procedure(s) and the length of stay;

(2) outpatient surgical or ambulatory surgical services, as defined in subsection (a) of this section;

(3) spinal surgery, as provided by Texas Labor Code §408.026;

(4) all psychological testing and psychotherapy, repeat interviews, and biofeedback; except when any service is part of a preauthorized or exempt rehabilitation program;

(5) all external and implantable bone growth stimulators;

(6) all chemonucleolysis;

(7) all myelograms, discograms, or surface electromyograms;

(8) unless otherwise specified, repeat individual diagnostic study, with a fee established in the current Medical Fee Guideline of greater than $350 or documentation of procedure (DOP). (Diagnostic study is defined as any test used to help establish or exclude the presence of disease/injury in symptomatic persons; the test can help determine the diagnosis, screen for specific

diseases/injury, guide the management of an established disease/injury and help formulate a prognosis.);

(9) work hardening and work conditioning services provided in a facility that has not been approved for exemption by the Division. A comprehensive occupational rehabilitation program or a general occupational rehabilitation program constitutes work hardening or work conditioning, respectively, for purposes of this section. All work hardening or work conditioning programs initiated on or after January 1, 2004 and prior to March 15, 2004, are subject to preauthorization and concurrent review. (For Division exemption approval for programs initiated on or after March 15, 2004, facilities must submit documentation of current program accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) to the Division. Division exempted programs and non-exempted programs are subject to Division verification and audit, and upon request shall submit specified information in the form and manner prescribed by the Division.);

(10) rehabilitation programs to include:

(A) outpatient medical rehabilitation; and

(B) chronic pain management/interdisciplinary pain rehabilitation;

(11) all durable medical equipment (DME) in excess of $500 per item (either purchase or expected cumulative rental) and all transcutaneous electrical nerve stimulators (TENS) units;

(12) nursing home, convalescent, residential, and all home health care services and treatments;

(13) chemical dependency or weight loss programs;

(14) any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care; and

(15) physical and occupational therapy services rendered on or after December 1, 2005.

(A) Physical and occupational therapy services are those services listed in the Healthcare Common Procedure Coding System (HCPCS) Level I code range for Physical Medicine and Rehabilitation, but limited to:

(i) Modalities, both supervised and constant attendance;

(ii) Therapeutic procedures, excluding work hardening and work conditioning; and

(iii) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code.

(B) Preauthorization is not required for the first two visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:

(i) the date of injury, or

(ii) a surgical intervention previously approved by the insurance carrier.

(i) The health care requiring concurrent review for an extension for previously approved services includes:

(1) inpatient length of stay;

(2) work hardening or work conditioning services;

(3) investigational or experimental services or use of devices;

(4) rehabilitation programs;

(5) DME in excess of $500 per item and TENS usage;

(6) nursing home, convalescent, residential, and home health care services;

(7) chemical dependency or weight loss programs; and

(8) physical and occupational therapy services.

(j) This subsection governs requests for voluntary certification of health care treatment and treatment plans, either prospectively or concurrently, that do not require preauthorization or concurrent review under subsections (h) and (i) of this section respectively.

(1) The requestor and carrier may voluntarily discuss health care, including pharmaceutical services, and/or treatment plans.

(2) The carrier may certify or agree to pay for health care requested under paragraph (1) of this subsection. The carrier and requestor should document the agreement.

(3) Carrier certification, or agreement to pay, subjects the carrier to liability in accordance with subsection (b)(2) of this section even if there has been a final adjudication that the injury is not compensable or that the health care was provided for a condition unrelated to the compensable injury.

(4) Denials of voluntary certification under this subsection are not subject to prospective necessity dispute resolution; however, health care for which voluntary certification was denied, is subject to retrospective necessity dispute resolution .

(k) An increase or decrease in review and preauthorization controls may be applied to individual doctors or individual workers' compensation claims, by the Division in accordance with §408.0231(b)(4) of the Texas Labor Code and other sections of this title.

(l) The carrier shall maintain accurate records to reflect information regarding requests for preauthorization, or concurrent review approval/denial decisions, and appeals, if any. The carrier shall also maintain accurate records to reflect information regarding requests for voluntary certification approval/denial decisions. Upon request of the Division, the carrier shall submit such information in the form and manner prescribed by the Division.

(m) Requests for preauthorization and/or concurrent review shall be responded to in accordance with rules in effect at the time of submission of the request. Where any terms or portions of this section are determined by a court of competent jurisdiction to be invalid, the remaining terms and provisions of this section shall remain in effect to the extent possible. If a portion of this section is declared invalid in a final judgment that is not subject to appeal, or is suspended by order of the court which is given immediate effect, the rule as it existed prior to the effective date of this section shall remain in effect for all requests for preauthorization to the extent necessary.